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DATE NOTICE SENT TO ALL PARTIES: Nov/10/2015

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: Lumbar epidural steroid injection at L5-S1

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION: DO, Board Certified Orthopedic Surgery

REVIEW OUTCOME: Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

[X] Upheld (Agree)
[ ] Overturned (Disagree)
[ ] Partially Overturned (Agree in part/Disagree in part)

Provide a description of the review outcome that clearly states whether medical necessity exists for <u>each</u> health care service in dispute. It is the opinion of the reviewer that the request for lumbar epidural steroid injection at L5-S1 is not recommended as medically necessary

PATIENT CLINICAL HISTORY [SUMMARY]: The patient is a male whose date of injury is xx/xx/xx. The patient injured his low back while attempting to lift the tailgate on his truck. CT of the lumbar spine dated revealed at L5-S1 there is mild circumferential disc bulging. MRI of the lumbar spine dated revealed at L5-S1 there is small diffuse 2 mm disc bulge causing mild central canal and mild bilateral neural foraminal stenosis. Note indicates that the patient complains of low back pain and bilateral leg pain. He is status post previous decompression laminectomy at L4-5 many years ago. Current right tib anterior strength is 3, left is 4. Right EHL/peroneus strength is 3, left is 4. Bilateral gastroc-soleus strength is 5. Physical therapy initial examination indicates that lumbar range of motion is limited. Strength is 3/5 in the upper and lower abdominals.

Initial request for lumbar epidural steroid injection at L5-S1 was non-certified on noting that there was lack of physical examination findings indicating significant neurological deficits such as decreased motor strength or sensation in a specific dermatomal or myotomal distribution at the requested levels corroborating with diagnostic studies. Moreover, there was lack of documentation the patient has had adequate conservative treatments to include exercise, physical methods, muscle relaxants and neuropathic drugs. The denial was upheld on appeal dated noting that with an acute injury, there was no documented failure of PT and muscle relaxants in the submitted document to warrant ESI. Therefore, the medical necessity of the request is not established and the previous determination is upheld.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION: The patient sustained injuries. There is no indication that the patient has received any conservative treatment to date. The Official Disability Guidelines require documentation that a patient has been initially unresponsive to conservative treatment prior to the performance of an epidural steroid injection. The Official Disability Guidelines require documentation of radiculopathy on physical examination corroborated by imaging studies and/or electrodiagnostic results. The submitted physical

examination fails to establish the presence of active radiculopathy. As such, it is the opinion of the reviewer that the request for lumbar epidural steroid injection at L5-S1 is not recommended as medically necessary and the prior denials are upheld.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

[ ] ACOEM-AMERICA COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE

[ ] AHCPR-AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES

[ ] DWC-DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES

[ ] EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN

[ ] INTERQUAL CRITERIA

[X] MEDICAL JUDGEMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

[ ] MERCY CENTER CONSENSUS CONFERENCE GUIDELINES

[ ] MILLIMAN CARE GUIDELINES

[X] ODG-OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES

[ ] PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR

[ ] TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS

[ ] TEXAS TACADA GUIDELINES

[ ] TMF SCREENING CRITERIA MANUAL

[ ] PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)

[ ] OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)